CAREGIVER TRAINING SCHOOL

1320 KALANI STREET SUITE 288 HONOLULU, HI 96817 TEL NO: (808) 848-9988 FAX NO: (888) 770-9021

PHYSICAL EXAMINATION FORM

Student information (please print):

Name________________________________ Sex: M___ F___ Birth date ____/___/______

Address:___________________________City____________Zip________Phone__________

Have you had a serious illness, injury, or surgery? If so describe:______________________

____

TO BE COMPLETED BY EXAMINING PHYSICIAN/NURSE PRACTIONER

1. Current complaints or disabilities pertinent to the student' education in Nurse Assistant or Home Health Aide Training Program____

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2. Medication used: Prescription and over-the counter (Use back if necessary).

Name	Reason	Frequency

3. Significant medical history major illness, accidents, deformities, surgeries, back problems, hepatitis, etc.____

____

4. Examination comments and Findings:____

FLU SHOT

(Please attach Proof)

Please give dates:

REQUIRED SCREENING FOR 2-STEP TUBERCULOSIS

P. P. D

(First Step.) Date_____________________ Results_______________________________

(Second Step.) Date_____________________ Results_______________________________

Chest X-ray (P. P. D. if positive) Date__________Results_______________________________

ATTACHED P. P. D. AND CHEST S-RAY RESULT FORM(S)

The above named has no communicable or disabling disease or any health condition that would create a hazard to himself, fellow employees, visitors, or to patients at this time. He/she is able to perform the physical activities required for the program for which the individual is applying.

Medical Examiner:____Phone ( )__________________

Address:____City/State/Zip_________________________

Signature:____Date:___________________________

Physician (M.D.) Or Physician's Assistant

Student's Signature:____

I give permission to release a copy of this form to affiliating clinical facility